MINNESOTA HOUSING FINANCE AGENCY

Rehabilitation Loan Program Authorization to Disclose Health Information

I,	, authorize	to release the
information identified below to		
	at	
	for the purpose of de	termining my eligibility for housing assistance.
Your certification	on of my diagnosis of:	
Your certification	on of my minor child's () diagnosis of:
Your certification	on of () diagnosis	of:
Other. (Be specinformation - See a	±	nation to be disclosed and the subject of that
	expires upon the earlier of the date of this authorization.	te you provide the requested information or two
	g you to disclose information abou uthority as a custodial parent.	at my minor children, my authorization is based on
2	for you to disclose information ab epresentative, as documented by t	out <u>(name of person)</u> is based on my authority to act the attached <u>(name of document)</u> .
Authorize	ed Signature	 Date
Type Name		

Health Insurance Portability and Accountability Act of 1996 Disclosures

(Name of borrower, tenant) may revoke this authorization by providing a written notice of revocation to (name of person and company/agency holding medical information to be disclosed), who is bound to comply with the request if the information requested in this authorization has not yet been provided.

(Name of person and company/agency holding medical information to be disclosed) may not withhold treatment, payment, enrollment, or eligibility for benefits if (name of borrower, tenant) does not sign this authorization.

It is possible that the information disclosed using this authorization will be redisclosed by <u>(name of caseworker/lender)</u> and will no longer be protected by federal law. However, state law prohibits <u>(name of caseworker/lender)</u> from disclosing this information without further authorization.